Dear Provider:

Thank you for your interest in participating as a provider of medical services for programs administered by the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP). The OWCP administers the Federal Employees' Compensation Act (FECA), the Black Lung Benefits Act (BLBA), and the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

OWCP has contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to those three programs. As part of their benefit structure, these programs reimburse medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable condition.

In order to process your bills, each provider must be enrolled with ACS. Please complete the enclosed provider enrollment form so that a provider identification number can be assigned to you. Instructions for completing the enrollment form and a list of provider types and specialty codes are also included.

The Debt Collection Improvement Act of 1996 includes the requirement that payments made by the Federal Government be sent by electronic funds transfer (EFT). EFT payments simplify and speed the billing process and reduce the incidence of billing errors. Therefore, an enrollment form for EFT is enclosed. A remittance advice listing all bills paid on each EFT transaction will be sent to your mailing address.

You must submit current licensure information on the completed enrollment application. Moreover you must maintain appropriate current licensure in order to receive payments under our programs. Where large group practices have providers in the group who are not providing medical services to our program on a regular basis, the group practice is responsible for monitoring the licensure of their entire group.

You may register as a participant in any or all three of OWCP's compensation programs. Please be sure to send the completed package(s) to the appropriate program(s) at the address (es) listed on P. 2 of the Form OWCP-1168.

Please be aware that OWCP, in an effort to assist claimants seeking medical services, is now providing an on-line search capability by one or more of the following: specialty, name, city, state, and zip code. The provider look up capability is meant as a customer service feature for those who may be seeking certain medical services in their area. The FECA program provides search capability for physicians enrolled in their program. In addition to physicians, the EEOICPA program is providing a search capability for home health aides and

hospice care. The Federal Black Lung Program (FBLP) will include all provider types for the provider look-up with the exception of provider type 53, non-medical vendors from the search. If for some reason you do not wish to be included in this service, please advise us in writing when you submit your enrollment application. Customers using this look-up feature will be advised that this is not an endorsement, referral or an agreement to reimburse for medical services rendered, as the fact that a provider is listed in no way constitutes an endorsement of the provider or that provider's services by the Department of Labor and OWCP. Nor does it guarantee that the medical provider will be reimbursed by OWCP for specific medical services that the provider has billed directly to OWCP or that a medical provider will agree to provide medical services to a particular claimant. The appearance of a specific medical provider's name in the listing of providers within a certain specialty does not require that provider to treat a particular claimant, even if OWCP has already advised the claimant in writing that medical treatment for a particular condition within the provider's listed specialty has been authorized.

You will be notified by mail once your enrollment package has been processed. Once you have received your ACS provider number, you may submit your bills to the appropriate program at the following address:

US Department of Labor
OWCP/FECA
P.O. Box 8300
London, KY 40742-8300

DEEOIC
P.O. Box 8304
London, KY 40742-8304

DCMWC/Black Lung
P.O. Box 8302
London, KY 40742-8302

If you have any questions regarding this information, please contact us at: 1-850-558-1818. Our business hours are Monday through Friday from 8:00 am to 8:00 pm, Eastern Time.

NOTICE: Please be aware that continued participation as a medical provider under the three DOL programs above is contingent on your maintaining good standing as a medical provider under other federal health benefit programs such as Medicare—exclusion as a medical provider in those circumstances operates as an automatic exclusion under the above-entitled programs administered by OWCP. (See e.g. 20 C.F.R. §§ 10.815, 30.715 and 702.431)

Provider Enrollment Form

U.S. Department of Labor
Office of Workers' Compensation Programs

OMB Number 1240-0021
Expires: 11/30/2012

Please refer to instructions for completing this form.

Provider Number	Effective Date

FOR DOL USE ONLY

1. Are you applying for a new enrollment or updating your record? ☐ New enrollment ☐ Update
   If update, enter Provider Number or Employer Identification Number (EIN):

1a. Program ☐ FECA ☐ Black Lung ☐ Energy

2. What is the earliest date that you treated a participant in any OWCP program?

Practice Information

3. Practice Name	4. Practice's Physical Address	
5. City	6. State	7. Zip (9 digits)
8. Telephone	9. FAX	9a. Email Address

10. Type of Practice a. ☐ Individual b. ☐ Facility (Provider Types: 01, 02, 03, 05, 46, 89, 90, 92, 93, 94)
c. ☐ Group (Please see reverse for completion of group enrollment)

Provider Type (Individual or Facility) (Please see attached listing)

11a. Provider Type Code	11b. Provider Type Description (see attachment)

11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

12. Tax ID: (EIN or SSN)

13. Required for hospitals only 13a. Medicare Number

13b. NPI:	1.	13c. Taxonomy Code(s):	1.
	2.		2.
	3.		3.

License and/or Certification required for all Applicants (Individual for M.D. and D.O. only)

14a. Name	14b. License No./ State	14c. Current License Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. United Mine Workers' of American (UMWA) Number, if applicable.

Billing Address-indicate "same" if identical to Practice Address.

16a. Address

16b. City	16c. State	16d. Zip (9 digits)

17. ☐ I have completed a ACH Vendor Payment/Electronic Funds Transfer (EFT) form.

18. ☐ I am interested in billing electronically (check one): ☐ P2P Link ☐ EDI ☐ Web Submission

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date

Group Provider Enrollment - #10c

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the list on page 4 the Provider Type code that most closely describes the service(s) that the professional provides. **Attach separate sheet for additional entries if necessary.**

Name	SSN/EIN	Provider Type Code	License No./ State	Current License No. Expiration Date	Specialty Code(s)	Certification Expiration Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

For Federal Employees' Compensation Act (FECA) Program:	*For Black Lung Program:*	*For Energy Program:*
OWCP/FECA P.O. Box 8300 London, KY 40742-8300	DCMWC/Black Lung P.O. Box 8302 London, KY 40742-8302	DEEOIC P.O. Box 8304 London, KY 40742-8304
If you have any questions regarding the completion of the form, please call Toll Free: 1-850-558-1818	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682

Privacy Act Statement

Collection of this information by OWCP is necessary for its administration of the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act and is authorized under 20 CFR 10.801, 20 CFR 30.701, and 20 CFR 725.704 and 725.705. The information provided will be used to ensure accurate payment of medical and vocational rehabilitation provider bills and is protected by the Privacy Act of 1974, as amended (5 USC 552a) in accordance with the following systems of records: DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49, published in the Federal Register, Vol. 67, page 16816, April 8, 2002, or as updated and republished. Completion and submission of this form is voluntary; however, failure to provide the information (including SSN or EIN) will result in substantially delayed payment of bills. This information will be furnished to OWCP and its data processing contractors, and may also be disclosed to other federal and state agencies in connection with the administration of other programs, to the Department of Justice for litigation purposes, and to medical and other provider review boards. Additional disclosures may be made through the routine uses for information contained in the referenced systems of records.

Public Burden Statement

Under the Paperwork Reduction Act, persons are not required to respond to a collection of information unless such collection displays a valid OMB control number. We estimate that it will take an average of 8 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS**

Instructions

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact Affiliated Computer Science or Office of Workers' Compensation Programs at the telephone numbers indicated on the form.

Block 1	Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or Employer Identification Number.
Block 1a	Check all programs in which you want to enroll as a provider.
Block 2	Indicate earliest date you treated any OWCP beneficiary.
Block 3	Type or print your practice name.
Block 4	Type or print your practice street address.
Block 5	Type or print your practice city.
Block 6	Type or print your practice state.
Block 7	Type or print your practice zip code (all nine digits).
Block 8	Type or print your practice telephone number.
Block 9	Type or print your practice FAX number (if applicable).
Block 9a	Type or print your practice email address (if applicable).
Block 10	Check your practice type---"a" for individual practice, "b" for a facility if you are one of the provider types listed (refer to the list of provider type codes below), or "c" for a group practice. Black Lung only: providers should disregard group practice information. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on page two of the form for each professional that will be providing services under the group Provider Number (name, Social Security number, provider type code from list below, license number and State, expiration date of current license, specialty code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
Block 11a	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your "Provider Type" code from the list below.
Block 11b	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print the "Provider Type" that corresponds with the code you entered in Block 11a.
Block 11c	If you checked "a" or "b" (individual practice or facility) in Block 10 and selected "Other Provider" (code 96) or "Non-Medical Vendor (code 53), please explain why you are enrolling.
Block 12	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.

Block 13a	For hospitals only, type or print your Medicare number.
Block 13b	For hospitals only, type or print your National Provider Identifier (NPI) number(s). Use as many lines as needed.
Block 13c	For hospitals only, type or print all applicable taxonomy codes.
Block 14a	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your name.
Block 14b	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your license number and State. **Attach a copy of current M.D. or D.O. license.**
Block 14c	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of your current license. This license must be kept current to continue receiving payment.
Block 14d	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your specialty code or codes from the list below.
Block 14e	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of any certification you currently hold.
Block 15	Type or print your UMWA Health & Retirement Funds Member Number, if any.
Block 16a	Type or print the address where you want your Remittance Advices and paper checks to be sent. If this address is identical to your billing address above in Blocks 4 through 7, indicate "same" and skip Blocks 16b, 16c and 16d.
Block 16b	Type or print your billing city if this is different from Block 5.
Block 16c	Type or print your billing State if this is different from Block 6.
Block 16d	Type or print your billing zip code (all nine digits) if this is different from Block 7.
Block 17	Indicate whether you have completed an ACH Vendor Payment or Electronic Funds Transfer (EFT) form.
Block 18	Indicate whether you are interested in billing electronically by checking the first box. If you check the first box, also indicate which of the three billing methods you will use.

* * * * * * *

Provider/Hospital Type Codes (Blocks 10c, 11a, and 11b)

01	General Hospital
02	Special Hospital/Outpatient Rehabilitation Facility
03	Psychiatric Hospital
05	Community Mental Health Center
19	End Stage Renal Hospital
20	Pharmacy
25	Physician (MD)

26	Physician (DO)
27	Podiatrist
28	Chiropractor
29	Physician Assistant
30	Advanced Registered Nurse Practitioner (ARNP)
31	Certified Registered Nurse Anesthetist (CRNA)
32	Psychologist
34	Licensed Midwife
35	Dentist
36	Registered Nurse (RN)
37	Licensed Practical Nurse (LPN)
38	Nursing Attendant
39	Massage Therapist
40	Ambulance
41	Contract Nurse
42	Air/Water Ambulance Company
43	Taxi
44	Public Transportation
45	Private Transportation
46	Hospice
50	Independent Laboratory
51	Portable X-Ray Company
52	Alternative Medicine
53	Non-Medical Vendor
54	Prosthetics/Orthotics
55	Vocational Rehabilitation (Training, Tuition and Schools)
56	Vocational Rehabilitation Counselor
57	Rehabilitation Maintenance
58	Assisted Re-employment
59	Relocation Expenses
60	Audiologist/Speech Pathologist
61	Second Opinion Contractor
62	Optometrist
63	Optician
65	Home Health Agency
66	Rural Health Clinic
68	Federally Qualified Health Center
69	Birthing Center
70	Health Maintenance Organization or Preferred Health Plan
71	Physical Therapist
72	Occupational Therapist
73	Pulmonary Rehabilitation
74	Outpatient Renal Dialysis Facility
75	Medical Supplies/Durable Medical Equipment (DME)
76	Case Management Agency
77	Social Worker
78	Blood Bank
79	Alternative Payee
80	Pay-to-Intermediary
88	Ambulatory Surgery Center
89	Federal Facility (VA Hospital)
90	Skilled Nursing Facility (SNF)-Medicare Certified
91	Skilled Nursing Facility (SNF)-Non-Medicare Certified
92	Intermediate Care Facility (ICF)
93	Rural Hospital Swing Bed
94	Boarding House

95	Insurance Company (Third Party Carriers)
96	Other Provider
97	Billing Agent
98	Lien holder

* * * * * * *

Provider Specialty Codes (Blocks 10c and 14d)

01	Adolescent Medicine
02	Allergy
03	Anesthesiology
04	Cardiovascular Disease
05	Dermatology
06	Diabetes
07	Emergency Medicine
08	Endocrine Medicine
09	Family Practice
10	Gastroenterology
11	General Practice
12	Preventative Medicine
13	Geriatrics
14	Gynecology
15	Hematology
16	Immunology
17	Infectious Diseases
18	Internal Medicine
20	Neoplastic Diseases
21	Nephrology
22	Neurology
24	Neuropathology
25	Nutrition
26	Obstetrics
27	Obstetrics and Gynecology
28	Occupational Medicine
29	Oncology
30	Ophthalmology
31	Otolaryngology
32	Pathology
33	Pathology, clinical
34	Pathology, forensic
40	Pharmacology
41	Physical medicine and rehab
42	Psychiatry
44	Psychoanalysis
45	Public Health
46	Pulmonary diseases
47	Radiology
48	Diagnostic radiology
50	Therapeutic radiology
51	Rheumatology
52	Abdominal surgery
53	Cardiovascular surgery
54	Colon and rectal surgery
55	General surgery
56	Hand surgery
57	Neurological surgery
58	Orthopedic surgery
60	Plastic surgery
61	Thoracic surgery
62	Traumatic surgery
63	Urological surgery
64	Other physician specialty
65	Maternal fetal medicine
70	Adult, dentures only
71	General dentist
72	Oral surgeon, dentist
74	Other dentist
88	Orthodontist
90	Occupational therapist
91	Physical therapist
92	Speech therapist
93	Respiratory therapist
99	Other

PAYMENT INFORMATION FORM
ACH VENDOR PAYMENT SYSTEM

This form is used for the ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearinghouse Payment System.

MEDICAL PROVIDER INFORMATION	
Provider #:	
Name:	
Address:	
Contact Person Name:	Telephone Number:

AGENCY INFORMATION	
Name: U.S. Department of Labor-Office of Workers' Compensation Programs	
Address: c/o ACS- Department of Labor Project	
P.O. Box 14600, Tallahassee, Florida 32317-4600	
Contact Person Name:	Telephone Number: 1 (866) 335-8319 Toll Free

FINANCIAL INSTITUTION INFORMATION	
Name:	
Address:	
ACH Coordinator Name:	Telephone Number:
Nine-Digit Routing Transit Number: ____ ____ ____ ____ ____ ____ ____ ____ ____	
Depositor Account Title:	
Depositor Account Number:	
Type of Account: ☐ Checking ☐ Savings	
Signature and Title of Representative:	Telephone Number:

SF Form 3881

Department of the Treasury
Financial Management Service

PAYMENT INFORMATION FORM INSTRUCTIONS (SF Form 3881)
ACH VENDOR PAYMENT SYSTEM

Section 1: **Medical Provider Information** (to be completed by the Medical Provider)
Print or type the 9-digit provider number and the name of the company, individual or institution that will receive the funds. The name and address should correspond to the name and address as it appears on the agreement, contract, claim or award document, etc. The provider's contact person and telephone number are also to be provided.

Section 2: **Agency Information** (to be completed by the Federal Agency)
Print or type the name and address of the fedral agency making the payment as well as the name of the agency contact person with telephone number.

Section 3: **Financial Institution Information** (to be completed by the FI)
Print or type the name and address of the FI and the name of the FI ACH / Direct Deposit Coordinator with telephone number. Print or type the 9-Digit Routing Transit Number (TRN). If the FI uses a processor, the RTN of the FI should be used. The name of the corporate customer is placed in the block entitled Depositor Account Title. Print or type the number of the account into which funds are to be deposited. Check type of account "Checking" or "Savings." The ***Financial Institution's representative*** signs the form and provides a telephone number for contact purposes.